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ABSTRACT

A study designed to assess health education in public schools in California, Nevada, and Utah is reported. Results are compared to those of the School Health Education Study (SHES) which was conducted twenty years ago. Information is provided on the needs, goals, programs, participants, and materials of school health education in large, small, and medium sized school districts. Data was gathered through interviews with key state personnel and questionnaires sent to school district personnel. While many concerns mentioned in both this study and the SHES overlap, changes have occurred in health education in the past 20 years. The introduction of education concerning abused substances at a much earlier age has recently been considered crucial. A trend is seen towards teaching health education as a separate subject beginning in the fourth grade. More required and elective health education courses are now offered in secondary schools. Findings suggest that while inservice opportunities for health educators are limited because of lack of funds, there is a more extensive use of existing health resources in the community. Greater cooperation between schools and the local community medical establishment is recommended. It is pointed out that improved local, state, and national level communication networks are needed. (JD)

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Dynamics of School Health Education in the Far West Laboratory Region: A Pilot Study

By
Matilda Butler and Jane Bunker

INDEPENDENT RESEARCH AND DEVELOPMENT PROJECT REPORTS
REPORT NO. 2

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U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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FAR WEST LABORATORY FOR EDUCATIONAL RESEARCH AND DEVELOPMENT

DYNAMICS OF SCHOOL HEALTH EDUCATION: A PILOT STUDY OF CALIFORNIA, NEVADA, AND UTAH

Matilda Butler, Principal Investigator

Jane Bunker, Project Associate

Report # 2

Independent Research and Development Project Reports

June 30, 1980

FAR WEST LABORATORY FOR EDUCATIONAL RESEARCH AND DEVELOPMENT

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FOREWORD

This report describes the results of one in a series of Independent Research and Development Projects funded by the Far West Laboratory for Educational Research and Development, using its own resources generated by fees earned on various contracts. These Independent Research and Development Projects, conducted by individual professional staff members of the Laboratory, represent pilot efforts that address new problem areas of significance to regional or national educational needs or that prove new resource or methodological areas heretofore unexplored by Laboratory staff.

Awards are made on a competitive basis annually or semiannually, depending on available funds. In addition to requirements that the projects be completed within nine months and require less than one quarter person year effort of any Laboratory employee, the proposals are scored on four criteria: (a) they must promise to open a new area of research or development or extend significantly the productivity of an existing areas, (b) they must be of high quality, (c) they must be difficult to fund through known private, governmental, or foundation funding, and (d) they must be closely related to the Laboratory's mission.

Following review by the Independent Research and Development Committee, recommendations for funding are forwarded through the Laboratory Director to the Program Committee of the Board of Directors of the Laboratory for their review and approval.

The following is a listing of the Independent Research and Development Project award recipients and a brief description of their projects.

Joahuin Armendariz. Development of Resources Relating to Systemic Design Models and Methodologies. This project tests the feasibility of developing instructional resources in design models and design methodologies for educational practitioners. Two monographs describing significant design approaches and key reference works will be prepared.

Ann Bouie. Identification of the Problematic Situation. The extent to which students assume responsibility for the acts that result in disciplinary measures as compared to the extent to which they see the causes as lying outside their control is the primary focus of this study. Though much of the literature explains student misbehavior, the vast majority of these explanations cite factors beyond direct student control, thus overlooking the potential influence of free choices, perceptions of acts, and contexts in which these occur.

Matilda Butler. Dynamics of School Health Education in the Far West Laboratory Region: A Pilot Study. School health education represents a challenge for the 1980s. The project is designed to provide information on the needs, goals, programs, participants, materials, etc., of school health education in Northern California, Utah, and Nevada.

Information is gathered through interviews with key state personnel and questionnaire sent to school district personnel.

Paul R. Christensen. Educational Use of Microcomputers. This project summarizes the current state-of-the-art on educational use of low-cost, high-capability, self-contained microcomputers; develops a taxonomy by which to characterize difficult computer-originated learning environments; and describes teacher perceptions of the "computer readiness" of students and the positive and negative factors in the learning environments.

Natividad DeAnda. Competencies of Leaders and Managers in Educational R&D. The study's goal is to produce an outline of competencies essential to successful management and leadership of educational projects, by analyzing job descriptions of managers and non-managers at the Laboratory for skill and knowledge areas utilized in their work. The study provides data for determining which competencies are considered essential to program management at the Far West Laboratory.

Jill S. Evenson. A Survey of Work-Related Attitudes of Professionals in Special Education. This study examines the attitudes toward work of teachers and administrators engaged in special education--persons who are in a position to exert strong influence on the developing work values of handicapped young persons. The study is seen as an exploratory step into needed research in work-related attitudes of handicapped young people and the effect on them of attitudes of their teachers.

J. Ronald Lally. Expanding Experiences and Employment for the Elderly Through Non-Center Based Family Child Care. This project is a needs assessment and feasibility study designed to investigate the possible creation of a system for delivering quality child care services and meaningful employment for the elderly in child care.

Chesca Piuma. Feasibility Study: Developing a Vocational Education Training Program for Severely Handicapped Adolescents and Young Adults. This study investigates the feasibility of developing five vocational education cirricula for severely handicapped (trainable mentally retarded) adolescents and young adults (ages 13-21) in the employment areas of gardening, housekeeping, laundry, minor auto maintenance, and food services.

The Far West Laboratory Independent Research and Development Committee:

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EXECUTIVE SUMMARY

In the past decade, we have seen the beginning of what appears to be a trend toward concern for health rather than for sickness. Understanding of health and healthful behaviors begins when we are children and continues into our adult years as our bodies continue to change. The knowledge and attitudes about health that children learn are acquired through the media, through family and friends, and through the schools.

Why study health education at Far West Laboratory for Educational Research and Development (FWL)? FWL has been concerned with quality of life issues since its beginning in 1966. Most recently, FWL's attention has again been focused on health education when this topic was identified as a high priority by the Needs Sensing and Program Review Committee of the Quality of Life Education Department.

This project is the direct result of that identified need to better address the issues of health education. We felt an important first step was to take a fresh look at what the schools in FWL's region (California, Utah, and Nevada) were doing about health education. Because FWL's Committee on the Review of Independent R&D Proposals and the FWL Board of Directors also thought school health education was a top priority, FWL sponsored this pilot study with its own funds.

The study had five phases. In Phase I, we conducted preliminary interviews to establish the context of school health education in FWL's region. We interviewed local school district health educators as well as state education agency personnel. In Phase II, we developed a school district questionnaire. Our preliminary interviews helped us to decide to

use the School Health Education Study (SHES) as the guide for our questionnaire. Findings from the extensive SHES are now approximately 20 years old. We hoped to develop a methodology to update that study and to make some comparison across the two sets of findings. In Phase III, we conducted the pilot study of school district health education programs. We chose 30 school districts -- 18 from California, 6 from Utah, and 6 from Nevada. There were 10 districts in each of three size categories (using SHES criteria). The overall response rate was 70%. In Phase IV, we compiled and analyzed the results of the pilot study. Although our findings from this small sample of districts cannot be taken as representative of the roughly 700 elementary, secondary, and unified school districts in California, Utah, and Nevada, our study has provided a tested methodology for a more extensive survey of school health education and begins to point to the kinds of changes that have occurred in the schools in the past 20 years.

The results of our pilot study suggest there have been some important changes in school health education in the past two decades. The introduction of education concerning abusive substances at a much earlier age is crucial if we are to influence young people before "hard-to change" behavior patterns begin. The trend towards teaching health education as a separate subject beginning in the fourth grade and as both a separate and an integrated subject in large districts' elementary schools is a sign that health topics are more apt to be adequately covered. There is also an indication that more required and elective health education courses are now being offered in secondary schools. Responsibility for these courses is shared among staff with health education, science, home economics, social studies and physical education backgrounds, rather than assumed by physical education or physical

education and health majors alone. More than 50% of the medium and large districts employ health educators. Although much of the inservice opportunities appeared to be limited, there were notable exceptions. Findings also suggest a much more extensive use of resources today.

But while change has occurred in the field of health education over the past 20 years, many of the SHES's recommendations remain valid today. Evaluation of existing programs is necessary in order to better understand the most effective way to communicate health information. Health education specialists are needed to coordinate each district's health instruction program K-12 and to tap the rich and varied community resources. Teachers need paid released time and better inservice opportunities in order to keep up with the rapidly changing information in this field. School health services, food services, health and physical education programs and the local community medical establishment must work together to establish the most comprehensive programs. Improved local, state, and national level communication networks are needed so that everyone may benefit from existing exemplary programs and resources.

Not only are young people surrounded by models of unhealthy behavior patterns in their daily lives, they are also bombarded with persuasive advertising campaigns that encourage these behaviors. Parents need to be involved and educated so that they can help to reinforce what is learned in school. Any health education program will be severely limited in its long range potential if it does not attempt to involve the young person's whole environment. Although much of the responsibility for health and well being is now placed on the individual, it is a collective responsibility to facilitate this process. The schools cannot do it alone.

ACKNOWLEDGEMENTS

Completion of this project was facilitated by many persons. Our first appreciation is extended to Far West Laboratory's Committee on the Review of Independent R&D Proposals and to the Program Committee of the FWL Board of Directors for funding this study.

Information collected from the interviews were possible because of the openness and graciousness of the following individuals: Gus Dalis; Linda Spaans Esten, Joan Haskins; Pat Hill; Gene Huber; Ron Luyet; Philip Nader; Robert M. Hirsh; Robert Leake.

And finally, our special thanks to the following individuals who responded to our survey: Elizabeth Wilhelm; Alyce Taylor; Rod Smith; Paul Billings; Tod Carlini; Mr. McOmber; Bry Sorensen; James MacFarlane; Donald L. Hughes; Frank Hall; R. Alden Black; Richard Towner; Ralph Vilani; Carolyn Harding; Joan Ainslie; Ron Luyet; Dr. Bert C. Corona; Mary Jane Quick; Mrs. Pat Allison; Douglas Campbell; Dr. Ruth Rich; Gene Huber; Mary Salocks; Helen Daniel; Mrs. Edna Morgan.

THE PROBLEM

Rapidly escalating health care costs coupled with mounting epidemiological evidence linking life style and chronic disease have contributed to a growing interest in preventive medicine. As risk factors such as smoking, diet, exercise and chronic stress are increasingly correlated with disease (especially heart disease), hope is being placed in the individual's ability to maintain or adopt healthy behavior patterns. Large scale interventions, (e.g., the Stanford, California and the Northern Karelia, Finland Heart Disease Prevention Programs),[1,2] suggest that not only can health related behaviors be modified, but that such modification will lead to a decrease in risk factors.

Although behavior change is possible, it is often refractory (e.g., recidivism in smoking cessation and weight loss). Ideally, preventive measures should begin before any risk increasing behavior becomes firmly entrenched. Multiple influences on developing behavior patterns indicate the importance of pooling resources to maximize this effort. Some researchers suggest a systems approach that integrates the child and family, school personnel and the educational system, and health care providers. The school is the natural place for this integration to occur. But while school health education offers a great resource for positively affecting health practices, numerous studies indicate that it has fallen short of its potential.

A first step in working with schools as they conduct health education programs is to determine the current status of health education in elementary and secondary schools.

HISTORICAL BACKGROUND

The School Health Education Study (SHES), begun in 1959, found deficiencies in school children's health knowledge and an indifference to and lack of support for health education on the part of many teachers, parents, administrators and the students themselves. The 1973 report of the President's Committee on Health Education stated "evidence abounds that health education in the schools is not effective, even when it is attempted." In 1977, Scott Simonds was quoted in The Journal of School Health as saying, "We are now witnessing considerable resurgent interest in health education...We are seeing a period of increased resource allocation in most social institutions, except in the schools [emphasis ours] and a period of increased legitimization in the field." 3

The findings of the President's Committee inspired the establishment of both the Bureau of Health Education (BHE) in the Center for Diesase Control in Atlanta, Georgia in 1974, and the National Center for Health Education (NCHE) in San Francisco and San Bruno in 1976. These offices in the public and private sector respectively work cooperatively on a variety of projects to promote school health education. The NCHE's contract with the BHE finances the School Health Education Project (SHEP) that encompasses the gathering of school health education data, the development of communication channels and resources as well as the evaluation and dissemination of the School Health Curriculum Project (SHCP) (grades 4-7).

Other BHE projects include:

1) The American Lung Association's Primary Grades Curriculum Project (PGCP) (K-3);
2) The National Congress of Parents and Teachers Comprehensive Health Education Project;
3) The Florida State Department of Education Managerial Model.

The SHCP, although sometimes criticized for its emphasis on the physiological component of health, has numerous strengths that can serve as guidelines for developing programs. For instance, strategies for team training and enlisting school and community support, the ready availability of resources, and the personal participatory approach to learning have distinguished it as an exemplary program. The PGCP was designed to "contribute significantly towards a positive self-image; thereby reducing risk-taking behavior and increasing the desire to maintain a healthy body." [4] It utilizes a "hands-on" approach with small and large group activities. It is suggested that this program be integrated into the total curriculum, rather than treated as an isolated subject.

Both the PTA project (see pp. 6 & 7) and the Florida model exemplify major concerns of the Bureau of Health Education. BHE is working for the integration of categorical programs into a comprehensive health education program including all community resources. The Florida model offers a prototype for the effective coordination of national, state and local health education resources. "We expect that a systematic 'how to' plan will evolve to aid a school district in utilizing the resources of available official, professional, and voluntary health and education organizations in a collaborative health education program." Special projects include a collaborative model formed by the Department of Education, the University of West Florida, and the Panhandle Area Education Cooperative "to provide technical assistance to county and school staffs; to conduct in-service programs; and to provide University level credit courses leading to certification in health education." [5] These programs should provide useful information for the development and dissemination of other comprehensive school health education programs.

In 1976 the National Consumer Health Information and Health Promotion Act (Title XVII of the Public Health Service Act) established the Office of Health

Information and Health Promotion (OHP) in the Office of the Assistant Secretary for Health. In July of 1979 this Office listed among its priorities:

1) the establishment of a National Clearinghouse for Health Information to be operational by early 1980;

2) the development and quality of health promotion in a) schools, b) worksites, c) medical treatment settings and d) communities.

Regulations for an Office of Comprehensive School Health have been developed with the Department of Education. Future efforts towards health education in the schools by the OHP will be coordinated with the BHE, the Department of Education and the NCHE.

While the trend at the State level is towards mandated comprehensive programs (see individual summary reports in Appendix A), available funding encourages a topic oriented approach. Institutes, bureaus, divisions and private agencies have historically funded categorical concerns, with only the BHE moving away from this pattern. The coordination of resources at Federal, State and local levels is crucial for a comprehensive approach to be viable. If the goal of health education in the schools is to "influence children to draw logical implications from what they have learned and to apply them to their daily life, we must deal with [these] subjects within a single framework and in the light of their common denominator--their effects on health. The improvement and safeguarding of one's health must be made the single, unifying principle that gives meaning and significance to each separate subject." [6]

However, accountability is necessary in order for programs to attract the much needed funding. Numerous authors stress evaluation as the key factor in the future of school health education programs, not only to encourage financial support, but to maximize the effectiveness of the development and delivery of curricula.

Evaluation can't take place without an agreement on objectives. At a school health education workshop in Denver in 1975, Marshall Kreuter and Patricia Reagan

suggested that it was naive to establish health behavior change as the criteria for the success or failure of a program. The majority of follow-up studies are too short to detect meaningful behavior change and there are too many variables involved to isolate a clear cause and effect relationship. A more realistic approach would be the evaluation of what Lawrence W. Green, Director of OHP, calls "enabling" and "predisposing" factors. Enabling factors are knowledge and skills while predisposing factors are attitudes and values. Both influence individual decision-making. For the complete evaluation of any health education program, Kreuter and Green provide a model that includes three possible levels that can be addressed: process, precurser, and outcome. Process evaluation involves assessment of organizational and teaching practices. Precurser evaluation is the assessment of those criteria (enabling and predisposing factors) found to have a high probability of affecting health outcomes. Outcome evaluation is the assessment of health practices on behaviors that have been hypothesized to show up over the long term. Such a complete evaluation effort is crucial if we are to make any headway in this important educational endeavor.

TECHNICAL PLAN

The problems and promise of school health education represents a challenge for the 1980s. This pilot study constitutes Far West Laboratory's initial response to that challenge.

PHASE 1: Conduct Preliminary Interviews

In order to establish the context of school health education in FWL's region, interviews were conducted first with local school district health educators and subsequently with state education agency personnel. Palo Alto and San Francisco were chosen for preliminary interviews in order to gain familiarity with the

issues of school health education, thus establishing guidelines for the state level interviews. Personnel at the state education agencies in California, Utah, and Nevada were interviewed.

PHASE II: Design School District Questionnaire

As a result of our interviews, we decided to use the School Health Education Study (SHES, 1961-63) as the guide for the development of our questionnaire. An effort was made to approximate the original SHES questions so as to facilitate data comparison. We attempted to design a questionnaire that would provide the maximum feedback with the minimum effort on the part of the respondents. The final questionnaire reflected not only the concerns of the original SHES, but those concerns which had been raised in the preliminary interviews as well.

PHASE III: Conduct Pilot Study of the School District Health Education Programs

Based on recommendations obtained during the interviews, we expanded the number of districts to be included in the survey. Ten large, ten medium and ten small districts were selected based on the SHES size criteria: Large - 25,000 and over; Medium - 3,000-24,999; and Small - 2,999 and under. Eighteen districts were chosen from California, six from Utah, and six from Nevada. Approximately one-third of the districts were recommended by state health education consultants as being exemplary. Others were chosen from the comprehensive list of districts to meet the stratified random sample of 6 small, medium, and large districts for California, the largest of the three states and 2 small, medium, and large districts for Nevada and for Utah.

CALIFORNIA

SMALL	MEDIUM	LARGE
Albany City (2,000-5)*	Berkeley (12,000-25)	Fresno (65,500-78)
Fall River Jt. (1,500-5)	Hayward (22,00-46)	Los Angeles (620,000-607)
Fort Bragg (2,500-7)	Modesto (21,000-30)	Sacramento (44,000-73)
Fowler (1,500-5)	Palo Alto (12,000-25)	San Francisco (68,000-707)
Jackson (700-2)	San Lorenzo (12,000-26)	San Jose (39,000-51)
St. Helena (1,500-5)	Santa Rosa (11,000-18)	Stockton (27,000-41)

NEVADA

SMALL	MEDIUM	LARGE
Lyon County (2,000-6)	Carson City (5,000-9)	Clark County (77,000-104)
White Pine Co. (2,000-12)	Elko County (3,500-18)	Washoe County (30,000-52)

UTAH

SMALL	MEDIUM	LARGE
Emery County (2,300-9)	Ogden City (12,000-26)	Jordan (37,000-39)
Garfield County (850-8)	Tooele County (6,000-15)	Granite County (61,000-74)

* Student body size and number of schools

Phone calls to the superintendent of each district were made to determine the appropriate persons to complete the questionnaire. The questionnaires were sent out on May 19. On June 10, a follow up phone call was made to those districts that had not responded.

PHASE IV: Interview Non-District Participants

Phase IV was eliminated from this pilot study as a result of information received in the preliminary interviews. Due to lack of coordination, non-district participants (medical societies, universities, professional associations, government agencies, health foundations, etc.) do not play a major role in most school health programs. Lack of organization of these community resources and time constraints of this pilot study prevented any evaluation by FWL at this time. However, future investigation of potential non district resources for school health education

and the contribution of communication and organizational expertise are suggested ways that FWL could provide valuable assistance.

PHASE V: Compile and Analyze Results of Pilot Study

In the final phase of this study, data from the preliminary interviews were summarized and sent to the appropriate respondents to be reviewed for accuracy (see Appendix A).Questionnaire data were reviewed and compared with similar data from SHES. Obviously our findings from this small sample of districts cannot be taken as representative of the roughly 700 elementary, secondary and unified school districts in the FWL region. The primary goal of the study has been to provide a tested methodology for a follow-on survey of school health education.

ANALYSIS AND RESULTS

It is important to acknowledge some of the confounding factors in the interpretation of data resulting from the questionnaires. While the questions called for an overall district account, personal interviews and other studies suggest that there is apt to be a great deal of variability from school to school within a district. State and local interviews also suggested that often no one person knows what is actually going on in each individual school. Responses may more accurately reflect a district's curriculum guide rather than any currently ongoing health education program. If this is the case and, as interview respondents suggested, most programs were better on paper than in practice, the questionnaire data may overstate the amount of health education actually being taught in the shools. The greatest validity may be assumed where interview and questionnaire findings agree.

A high degree of response variability between district sizes influenced our decision to focus our analysis on these differences, rather than any between the three states. Comparison of data by state would have reflected response bias within school district size category rather than valid state differences. Although

this pilot study does not allow for detailed comparison with the SHES findings, strong apparent differences and similarities will be noted.

Response Rate

Thirty-three questionnaires were sent out to thirty school districts: six of these going to three districts that were not unified. The overall response rate was 70%. Of the small districts seven out of eleven were returned. One district answered questions 1 and 7 on the telephone. (N_e-7, N_s-8,[1] for questions 1 and 7, and N_e-6, N_s-7, for questions 2-6). Of the medium districts, seven out of eleven were returned. (N_e-6, N_s-7). Of the large districts, nine out of eleven were returned. (N_e-8, N_s-8).[2]

Findings

Interviews

Because there was little current information on school health education in California, Utah, and Nevada (Far West Laboratory's region) we began our study with a series of interviews with state and local officials. These interviews highlighted several problems. The most common problem frequently mentioned was the lack of financial support for instructional improvement (see Appendix A). The percentage of health educators and staff with adequate health education preparation is still small. Staff at the state department of education in all three states indicated that limited funding for inservice training was a serious obstacle facing school health education today. At the local level, those interviewed

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1 N_e - elementary, N_s - secondary

2 One questionnaire was received too late to include in the analysis. It would have raised the response rate to 73%.

spoke of the following problems:

1) numerous materials and carefully developed plans often go unused as a result of insufficient in-service training;
2) the wealth of community resources that go untapped because the districts cannot afford to hire someone to coordinate them;
3) teachers are not able to take advantage of materials without more teacher-released time provided.

These recurring themes serve as a reminder of the overall lack of commitment to school health education. Among other educational concerns, it is still considered a low priority item.

Whereas in the past school boards have been motivated to respond primarily to crises (i.e., drugs, VD, or unwanted pregnancy) with some support for short term topic-oriented health units, there is some indication that this is changing. The National Congress of Parents and Teachers, under contract to the BHE, has demonstration projects in eight states to increase community awareness of the need for comprehensive school health education programs. These pilot projects focus on a variety of different activities including:

1) the development of school/community health education councils to stimulate public awareness;
2) multimedia presentations by PTA members to school boards and community organizations to generate support for comprehensive school/community health education projects;
3) the development and implementation of programs that focus on parents and teachers as role models for positive health behavior, and
4) the initiation of health resource centers.

The California PTA project, Awareness and Action, has had a positive effect on attitudes toward comprehensive school health education in California. Sixty-four trained PTA members in 1976 and in 1977 made over 100 multi-media presentations to boards of education. As a result of this, the Comprehensive Health Instruction Framework was approved by the California State Board of Education in March of 1977.

The framework emphasizes the following four areas of growth:

1) growth in self awareness
2) developing skills for effective decision making
3) growth in the ability to cope and initiate action and
4) developing understanding, decision making skills and health behaviors in specific health areas.

PTA members continue to make presentations in local districts to generate support for comprehensive school health education and encourage use of the State Framework.

The Utah Department of Education was also appreciative of the efforts of the PTA. The Utah PTA recently lobbied successfully for a $150,000 grant to improve materials and instructional strategies.

These results are just a small indication of what is possible when resources are pooled. But unfortunately, despite isolated examples of excellence, school health education is suffering from mediocrity and neglect. Recent financial cutbacks to education underline the importance of enlisting community expertise and support. Only then might we be able to offer each individual the freedom to make informed, rational decisions contributing to his/her own and others health and well being.

Survey

Coverage of Topics. Topics most often covered at some grade level included Food and Nutrition (74%), Smoking (73%), Drugs and Narcotics (71%), and exercise and Relaxation (70%). Topics least often covered included Sex Education (48%), Weight Control (51%), and Parenthood and Childcare (51%). (See Table #1). The School Health Education Study (SHES) also found a frequent omission of Sex Education in the school curriculum.

TABLE #1 PERCENT OF DISTRICTS COVERING INDIVIDUAL TOPICS AT ANY GRADE LEVEL

Food and Nutrition	74%	Mental Health	57%
Smoking	73	Diseases and Disorders	57
Drugs and Narcotics	71	Community Health	56
Exercise and Relaxation	70	Dental Health	56
Alcohol	67	Environmental Hazards	56
Consumer Education	56	Skin Care	55
Personality Development	64	Health Careers	54
Vision and Hearing	64	Venereal Diseases	54
Family Life	61	Parenthood & Childcare	51
Accident Prevention	60	Weight Control	51
Stucture and Function of the Human Body	60	Sex Education	48
Physical Changes During Growth	58		

As district size increased, the percentage of topics covered at any grade level by a majority of the districts in that size category also increased. (Small - 48%, Medium - 91% and Large - 96%) (See Table 2, pp. 13-14).

TABLE 2. PERCENT OF DISTRICTS COVERING HEALTH EDUCATION TOPICS, BY DISTRICT SIZE AND GRADE LEVEL.

TOPIC	DISTRICT SIZE	ELEMENTARY		SECONDARY					OVER-ALL
		K-3	4-6	7-8	9	10	11	12	
Accident prevention & safety	Small	57%	71%	75%	38%	50%	13%	25%	47%
	Medium	100	83	71	57	86	43	43	69
	Large	100	100	88	50	75	13	25	64
Alcohol	Small	29	71	63	63	63	38	50	54
	Medium	50	67	86	57	100	71	86	74
	Large	50	100	100	63	88	38	63	72
Community health	Small	14	29	50	38	63	25	38	37
	Medium	67	67	71	43	71	71	71	66
	Large	88	100	88	38	75	25	38	65
Consumer education	Small	29	57	63	63	63	50	75	57
	Medium	50	50	29	86	86	86	100	70
	Large	75	100	75	63	88	38	63	72
Dental health	Small	86	71	50	25	50	25	25	47
	Medium	100	100	71	43	57	43	29	63
	Large	100	100	75	38	50	25	13	57
Diseases & disorders	Small	29	57	50	38	63	25	38	43
	Medium	50	67	71	43	86	43	43	57
	Large	63	88	100	63	88	38	50	70
Drugs and narcotics	Small	43	71	75	50	63	38	63	58
	Medium	67	67	100	71	100	71	71	78
	Large	75	100	100	63	88	50	63	77
Environmental hazards	Small	29	29	75	38	50	25	25	39
	Medium	67	83	57	43	86	57	43	62
	Large	88	100	75	50	75	38	50	68
Exercise & relaxation	Small	57	57	75	63	75	63	75	66
	Medium	50	50	71	71	100	57	57	65
	Large	88	100	88	75	75	63	63	79
Family life	Small	43	43	63	63	75	63	75	61
	Medium	67	67	57	29	86	57	57	60
	Large	75	88	75	50	63	25	63	63
Food & nutrition	Small	71	86	63	63	63	50	63	66
	Medium	67	83	86	57	86	71	71	74
	Large	100	100	100	75	88	50	71	82

TABLE 2 (CONTINUED).

TOPIC	DISTRICT SIZE	ELEMENTARY K-3	ELEMENTARY 4-6	SECONDARY 7-8	SECONDARY 9	SECONDARY 10	SECONDARY 11	SECONDARY 12	OVER-ALL
Health careers	Small	0	29	38	63	75	50	38	42
	Medium	50	67	29	71	100	71	71	66
	Large	38	75	75	38	88	25	38	54
Mental health	Small	29	57	38	38	75	38	38	45
	Medium	50	50	43	57	86	71	71	61
	Large	75	75	75	63	75	38	50	64
Parenthood & childcare	Small	0	14	38	25	75	75	75	43
	Medium	33	33	14	29	57	86	86	48
	Large	38	63	63	50	75	63	75	61
Personality development	Small	57	71	63	63	75	50	50	61
	Medium	33	33	29	57	100	86	71	58
	Large	88	88	88	63	75	50	50	72
Physical changes during growth	Small	14	57	75	50	50	38	50	48
	Medium	33	67	86	29	86	71	57	61
	Large	63	88	88	63	63	38	50	65
Sex education	Small	14	29	38	50	75	50	38	42
	Medium	33	67	86	29	71	71	71	61
	Large	13	75	63	38	50	13	38	41
Skin care	Small	43	57	63	38	63	38	38	49
	Medium	50	50	71	43	57	57	57	55
	Large	88	100	63	50	50	38	38	61
Smoking	Small	57	86	63	75	75	50	63	67
	Medium	67	83	100	43	100	71	57	74
	Large	63	100	100	75	88	50	63	77
Structure & function of the human body	Small	14	57	75	38	63	50	50	50
	Medium	50	67	100	43	86	43	43	62
	Large	75	88	88	63	63	50	50	68
Venereal diseases	Small	0	29	75	50	75	38	50	45
	Medium	17	17	86	57	100	71	71	60
	Large	13	38	100	63	88	38	63	57
Vision & hearing	Small	86	86	63	50	50	50	50	62
	Medium	83	100	57	57	86	43	43	67
	Large	88	100	75	50	50	38	50	64
Weight control	Small	43	71	63	50	63	50	63	58
	Medium	17	17	43	43	57	43	43	38
	Large	38	75	75	50	63	38	50	56

Overall topic coverage was most extensive in grade ten. As district size increased, there was a tendency for greater coverage in the lower grades. (See Table #3).

TABLE #3 PERCENT OF ALL TOPICS COVERED, BY DISTRICT SIZE AND GRADE LEVEL

	K-3	4-6	7-8	9	10	11	12
Small:	37%	56%	60%	49%	65%	43%	51%
Medium:	54	63	66	50	84	63	61
Large:	68	88	83	57	72	38	51
Average:	53	69	70	52	74	48	54

Comparison with SHES

A comparison of grade level of topic introduction between the SHES and the FWL data indicates an important trend towards reaching children at younger ages.

TABLE #4 GRADE LEVEL OF TOPIC INTRODUCTION - SHES AND FWL

TOPIC	SHES	FWL
Smoking	7	K-3
Drugs and Narcotics	10-12	K-3
Mental Health	10-12	K-3
Alcohol	10-12	4-6
Weight Control	10-12	4-6

Elementary Health Education: Taught as a Separate Subject, Integrated, or Both. A high degree of response variability and the small sample size inhibit much analysis of this question by district size. The only general finding was a trend toward teaching health education both as a separate course and integrated

into other subjects as district size increased. (Small - 17%, Medium - 33% and Large - 54%). Combining size categories, there was a definite trend toward teaching health education as a separate subject with increasing grade level. (See Table #5).

TABLE #5 PERCENT OF DISTRICTS REPORTING THAT HEALTH EDUCATION IS INTEGRATED, TAUGHT AS A SEPARATE SUBJECT OR BOTH IN THE ELEMENTARY GRADES, BY GRADE LEVEL

	K	1	2	3	4	5	6	Ave.
Separate:	40%	50%	55%	65%	65%	70%	80%	(61%)
Integrated:	70	65	70	65	55	50	50	(68)
Both:	35	35	35	40	35	35	40	(36)

Comparison with the SHES

Although the SHES also found a high degree of response variability with respect to grade level, they found that a majority of districts integrated health education in K-6, but that it was taught more often (72% of the time) as a separate subject from 4-6. The SHES reported that research evidence from other studies indicated that teaching health education as a separate course was more effective than integrating or correlating it with other subjects in the curriculum. Further investigation is necessary to conclude when, where and how health education topics are best included.

Separate Secondary Health Education Courses: Required Courses. Analysis of the responses to this question of required courses is difficult because of the variation of courses listed. One hundred percent of the small districts, 86% of the medium districts and 100% of the large districts require at least one health education course from 7-12 listed under the following titles:

"Health," "Health Education," "Drivers Education and Health," "Family Health and Sex Education," "Family Life Education," "Family Living" and "Sociology/ Parenting." Also listed as required health education courses were: "Physical Education," "Drivers Education," "Science," "Social Studies," and Biology." With these courses included, 100% of all districts require at least one "Health Education" course, with the majority required from grades 9-12. Comparison with the SHES (See Table #6).

Whereas the SHES found the majority of required health education courses were offered in grades 7 and 8, the FWL study found a much greater emphasis in grades 9-12.

TABLE #6 PERCENTAGE OF DISTRICTS REQUIRING HEALTH EDUCATION COURSES IN GRADES 7 & 8 and 9-12

	Grades 7 & 8		Grades 9-12	
	SHES	FWL	SHES	FWL
Small:	48%	29%	25%	100%
Medium:	62	57	37	86
Large:	55	63	24	100

Separate Secondary Health Education Courses: Elective Courses. Courses included as elective health education courses were listed under such diverse titles as "Contemporary Living," "Home Economics," "Peer Counseling," "Life Saving," "On Your Own," "Exploring Health Careers," "Medical Preparation," "Physiology," "Stress and Relaxation," and "Parenting and Decision Making." Variations in response may partially reflect differing interpretations of "Separate health education course."

Comparison with the SHES

Our study shows a smaller percentage of districts offering separate courses in grades 7 & 8 than did the SHES and a greater percentage in grades 9-12. The large districts are the exception. (See Table #7).

TABLE # 7 PERCENTAGE OF DISTRICTS OFFERING ELECTIVE COURSES IN GRADES 7 & 8 and 9-12

	Grades 7 & 8		Grades 9 - 12	
	SHES	FWL	SHES	FWL
Small:	48%	-	31%	86%
Medium:	69	43	43	57
Large	61	25	52	50

Grade Level of Elective and Required Courses. Required courses are most often taught in the tenth grade in all three district size categories, whereas elective courses are most often offered in the eleventh and twelfth grades. This emphasis on health education in the tenth grade agrees with the findings in Table #2. (See Table #8)

TABLE #8 PERCENTAGE OF REQUIRED AND ELECTIVE COURSES OFFERED AT EACH GRADE LEVEL BY DISTRICT SIZE

REQUIRED	7	8	9	10*	11	12
Small	6%	11%	29%	39%	11%	6%
Medium	28	17	11	28	6	11
Large	26	11	11	42	5	5
Average	20	13	17	36	7	7
ELECTIVE	7	8	9	10	11	12
Small	-	-	5	14	38	43
Medium	10	10	7	27	23	23
Large	7	13	13	7	33	27
Average	6	8	8	16	31	31

Who Teaches? Forth-three percent of the small districts, 71% of the medium districts and 63% of the large districts reported employing health educators. Although never a majority, health educators are credited with teaching required health education courses most often in the medium and large districts; physical education teachers most frequently teach health education in the small districts. Home economists are most likely to teach elective health education courses in small and medium districts; health educators in large. Others often responsible for health education courses include science and social studies teachers for small and medium districts' required courses and the school nurse for small districts' elective courses. (See Table #9).

TABLE #9 PERCENT OF COURSES TAUGHT BY SUBJECT SPECIALISTS, BY DISTRICT SIZE

	REQUIRED				ELECTIVE			
	Small	Medium	Large	Average	Small	Medium	Large	Average
Health Ed.:	20%	33%	41%	31%		25%	29%	21%
Home Econ:	-	8	-	3	30	31	21	27
Phys. Ed.:	33	8	29	23	9	6	6	7
Soc. Stud.:	20	25	12	19	9	19	21	16
Sc. Nurse:	7	-	-	2	26	-	-	9
Science:	20	25	6	17	17	13		12
Other:	-	-	12	4	-	6	14	7

Comparison with the SHES

Whereas the SHES found the majority of health education classes to be taught by someone with a combined health and physical education major, or a physical education major only, (for grades 7 & 8, 80% small and medium and 60% large; for grades 10-12, 60% small and 90% medium and large), FWL's study found a much greater variation in background among those responsible for health education courses.

Courses in Which Health Units are Included. Health education units were reported as most often being integrated into home economics classes. Physical education and general science were the only other subjects in which health education units were integrated more than 50% of the time. (See Table #10).

TABLE #10 PERCENT OF DISTRICTS INTEGRATING HEALTH EDUCATION UNITS INTO SPECIFIC OTHER SUBJECTS

SCIENCE	7	8	9	10	11	12	Average - All Grades Combined	Average Size and Grade Combined
Small:	43%	57%	57%	43%	43%	29%	45%	
Medium:	43	43	43	43	-	-	29	41%
Large:	63	50	63	50	38	38	50	
HOME ECONOM.								
Small:	14	29	71	57	71	86	55	
Medium:	29	57	100	86	86	71	71	61%
Large:	50	50	63	63	63	63	58	
PHYS. EDUC.								
Small:	43	43	100	86	71	57	67	
Medium:	57	71	57	43	43	29	50	51%
Large:	38	38	38	38	38	25	35	
SOCIAL STUDIES								
Small:	29	43	29	29	43	43	36	
Medium:	-	-	14	43	29	57	24	28%
Large:	13	13	25	25	25	38	23	
OTHER								
Small:	-	-	-	14	14	29	10	
Medium:	-	14	-	14	-	-	5	8%
Large:	-	-	13	13	13	13	8	

The SHES data, with size of district combined, and 7 & 8 separated from 9-12, found the following rank orders in which health education units were integrated a majority of the time into other subjects:

7 & 8	9 - 12
1. General Science	1. Physical Education
2. Home Economics	2. Home Economics
3. Physical Education	3. Science

Inservice Training. This question, designed to assess the percentage of teachers of health education courses who receive inservice training, produced the most variability in responses, including blanks, question marks and "UNKNOWNS." Interviewees at the state and local level all spoke of the pressing need for more in-service training. The spotty questionnaire data confirms this need for better organized and readily available programs, along with financed teacher released time. While many districts reported no opportunities or limited inservice opportunities, almost one third reported that 90 or 100% of their teachers received inservice training.

Comparison with the SHES

The SHES found "limited" opportunities for inservice at the elementary level. They did not assess inservice at the secondary level. Although we found some notable exceptions, the majority of school districts in FWL's study reported a small percentage of teachers receiving inservice training.

Resources. More than 50% of all districts responding use state and local education codes or guidelines and commercially published texts or materials as major resources for both elementary and secondary schools. Locally developed teaching units were also considered a major resource by a

majority of medium and large districts. Community police or fire personnel and agency guidelines, texts and materials (such as the Dairy Council), were most often cited as minor resources. Texts and materials derived from research and development were cited as a minor resource in the majority of secondary but not elementary schools. Both medium and large districts reported major use of more resources than did small districts. (See Table #11).

Comparison with the SHES

The SHES found two-thirds to three-fourths of all respondents used textbooks. Over 70% of FWL's respondents also reported textbooks as a resource. But whereas the SHES found textbooks and state guidelines to be the most frequently cited resources for K-6, FWL's study shows a much broader use of resources. The SHES found the state course of study to be the lowest resource for 7-12, while we found it to be one of a majority of major resources.

Problems. The percentage of districts identifying problems rose as district size increased. Lack of a coordinated program through the grades was most often mentioned as a concern for small districts. Medium and large districts most frequently noted inadequate preparation of classroom teachers, failure of parents to encourage practice of health habits learned in the school, student indifference to issues of good health and shifting state and federal emphasis from one "fashionable" health topic to another as their main concerns. A majority of medium districts also emphasized community opposition to controversial topics and a majority of large districts mentioned the lack of time for health education in the classroom.

Comparison with the SHES

The SHES also found more problems reported as district size increased. Combining their elementary and secondary responses, we found six of the above listed concerns among their top eight problems. The only differences were

TABLE 11. PERCENT OF DISTRICTS REPORTING MINOR AND MAJOR USAGE OF HEALTH EDUCATION RESOURCES IN ELEMENTARY AND SECONDARY GRADES, BY DISTRICT SIZE.

RESOURCE	DISTRICT SIZE	ELEMENTARY		SECONDARY	
		Minor	Major	Minor	Major
State education code or state guidelines for health education	Small	17%	67%	0%	86%
	Medium	17	83	0	100
	Large	13	63	38	50
Local education code or guidelines	Small	67	17	71	14
	Medium	33	67	29	71
	Large	13	63	13	75
Guidelines prepared by other agency (e.g., Red Cross, Dairy Council, American Dental Association)	Small	50	33	71	14
	Medium	67	17	43	29
	Large	50	25	75	0
Locally developed teaching units	Small	0	33	57	29
	Medium	33	67	0	100
	Large	0	50	0	75
Texts/materials supplied by agency	Small	50	33	57	29
	Medium	67	33	71	29
	Large	63	13	63	13
Texts/materials derived from research and development (e.g., National Center for Health Education)	Small	50	17	71	14
	Medium	33	17	71	14
	Large	50	13	63	13
Commercially published texts/materials	Small	17	67	29	57
	Medium	33	50	14	57
	Large	13	63	0	88
District-level health educators or other specialists	Small	67	17	43	14
	Medium	33	33	57	29
	Large	38	38	63	25
Community physicians, dentists, nurses or nutritionists	Small	67	0	57	14
	Medium	50	33	43	43
	Large	38	38	75	13
Community police or fire personnel	Small	67	0	57	14
	Medium	67	17	71	0
	Large	63	13	88	0
Health agency staff or volunteers	Small	50	17	43	29
	Medium	67	17	71	29
	Large	50	13	75	0

"the shifting of state and federal emphasis" as one of the majority concerns in our study, and the need for improved instruction in some areas and a lack of enthusiasm on the part of teachers and administrators as two of the SHES's concerns.

SUMMARY AND RECOMMENDATIONS

Although many of the concerns mentioned in both studies overlap, our data suggests some important changes have occurred in school health education in the past 20 years. The introduction of education concerning abusive substances at a much earlier age is crucial if we are to influence young people before hard-to-change behavior patterns begin. The trend towards teaching health education as a separate subject beginning in the fourth grade and as both a separate and integrated subject in large districts' elementary schools is a sign that health topics are more apt to be covered. There is also an indication that more required and elective health education courses are now being offered in secondary schools. Responsibility for these courses is shared among staff with health education, science, home economics, social studies and physical education backgrounds, rather than assumed by physical education or physical education and health majors alone. More than 50% of medium and large districts employ health educators. Although much of the inservice opportunities appeared to be limited, there were notable exceptions. Findings also suggest a much more extensive use of resources today.

But while change has occured in the field of school health education over the last 20 years, many of the SHES's recommendations remain valid today. Evaluation of existing programs is necessary in order to better understand the most effective way to communicate health information. Health education specialists are needed to coordinate each district's health instruction program K-12 and to tap the rich and varied community resources. Teachers need paid released time and better inservice

opportunities in order to keep up with the rapidly changing information in this field. School health services, food services, health and physical education programs and the local community medical establishment must work together to establish the most comprehensive programs. Improved local, state, and national level communication networks are needed so that everyone may benefit from existing exemplary programs and resources.

Not only are young people surrounded by models of unhealthy behavior patterns in their daily life, they are bombarded with persuasive advertising that encourages these behaviors. Parents need to be involved and educated in order to assure reinforcement of what is learned in school. (See Palo Alto U.S.D. summary report - Appendix A.) Any health education program will be severely limited in its long range potential if it doesn't attempt to involve the young person's whole environment. Although much of the responsibility for health and well being is now being placed on the individual, it is a collective responsibility to facilitate this process; the schools cannot do it alone.

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APPENDIX A - INDIVIDUAL INTERVIEW REPORTS

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CALIFORNIA - Gus Dalis (Health Education Consultant, Office of Los Angeles County Superintendent of Schools)

Gus Dalis, Health Education Consultant for the Office of the Los Angeles County Superintendent of Schools, confirmed the need for a status study and suggested the possibility of a 20 year comparison with the data gathered by the School Health Education Study (SHES). This led to the use of SHES Summary Report as a guideline for Far West Laboratory's preliminary questionnaire. Gus reiterated that neither he, nor the state,had the data we wanted.

Los Angeles County is made up of 82 school districts and 13 community college districts and only one of those districts has a health educator whose sole purpose is to coordinate school health education (Dr. Ruth Rich - Los Angeles County School District). Others who have been designated the responbility for health education may have as many as five other subject areas for which they are accountable.

Instructional improvement has been hardest hit by the cutbacks in educational funding, exaccerbating the critical need for money for teacher released time. Any other assistance is wasted at this time as teachers are not free to take advantage of it. An illustrative example is the situation of the small district of San Marino. Although a group of educators put in large amounts of time with Gus developing a tailor-made health curriculum for their district, much of it may not be taught, as the requisite accompanying in-service will be difficult to fund.

Gus spoke about the problem of topic funding (NET)* and crisis funding (the 1968 Federally funded drug programs precluded the inclusion of alcohol education) as they undermine California's efforts towards comprehensive health education and was critical of the narrow approach of the School Health Curriculum Project (SHCP). While it almost exclusively emphasizes the physiological component in health, Gus stressed the importance of the emotional, cognitive and social components as well. He was very supportive of the SHES curriculum guide which is being used in the Long Beach USD under the guidance of Sandy French. The SHES curriculum is compatible with the California Framework which emerged after the SHES and is quite similar in design and approach.

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* See pp. 31-32

CALIFORNIA - Linda Spaans Esten (Nutrition Education and Training Specialist, Nutrition Education and Training Program)

The Nutrition Education and Training Program (NET) in California, under the direction of Amanda Dew Mellinger, operates out of the office of Child Nutrition Services in the State Department of Education with funding from both State and Federal sources. This particular office placement was to assure maximum coordination between the cafeteria and the classroom. State legislation (SB 120) 1975, The Child Nutrition Facilities Act, provides $600,000 per year for local nutrition education projects. Federal legislation (PL95-166), 1978, The National School Lunch Act and Child Nutrition Ammendments originally provided .50 per child nationally, but has since been reduced. California received a total of 2.4 million dollars the first year, 1.8 this year, and expects the program to continue, although with a slight decrease in funding for 1981.

NET addresses four major components in its campaign to improve nutrition, particularly among young people, in California. These include support for local projects, the development of a comprehensive nutrition education curriculum for K-12, staff development and community education and a media campaign to promote interest in nutrition education. While State money provided for the initiation of the original 28 local projects, State and Federal monies have since been combined and are shared among these four components. This year, over 150 local projects have been funded; 6 exemplary, 80 developmental and 75 adoption. Grant proposals for local funding must specify plans for student instruction, staff in-service training (including food services), materials development and procurement, and parent/community education and participation. Materials from 6 exemplary districts are currently available from Title 4C Resource Centers in Oroville, San Jose, and Downey, and plans are underway for a resource center solely for housing NET developed materials and information.

The early work of these local projects aided in the development of minimum proficiency levels by staff members of the State Department of Education. Food Services Representatives, Nutrition Education and Curriculum specialists and teachers. The minimum proficiency levels support the nutrition concepts in the Health Instructional Framework for California public schools and are continually being revised. They provide the foundation for the development of a sequential comprehensive nutrition education curriculum for K-12 by task forces under the guidance of Mary Weaver, NET specialist. A curriculum for K-6 with a built-in comprehensive evaluation component is being piloted throughout the State, and should be available for distribution by Fall of 1980. A 7-12 curriculum now being developed will be piloted in health education and home economics classes and has a projected availability time of September 1981. This curriculum will also include supplementary lessons to be integrated into english, science, social studies, art, language and physical education classes. Training networks are proposed for the most effective diffusion of this curriculum.

Next year will see an expansion in the Staff Development/Community Education and Media Campaign components. Intensive efforts will be aimed at getting parents, food service personnel, teachers, athletic coaches, school administrators and young people to work together. Some of the local project areas have already demonstrated an impact in their community, most notably the Los Angeles Unified School District, whose school board has tackled an emotional issue and banned the sale of "junk foods" to be effective September 1980. There are tentative plans to set up a phone evaluation of parents in local project areas to assess if and how the program has changed their eating habits at home.

Evaluation of knowledge and attitude change is built into the developing curricula, with pre-and post-tests and an assessment of teacher proficiencies. An attempt is also made to measure behavior change via pre- and post-plate waste surveys. There are too many variables involved for this to be a valid or reliable measure. An overall evaluation report for NET in California will be compiled at the end of each year and a national NET evaluation is underway. It is hoped that longer range follow-up studies will indicate meaningful behavior change in the making of wise food choices.

Due to its head start with the local projects and the input of the NET staff along with representatives from local education agencies, professional associations, advocate organizations, parents and the State Child Nutrition Advisory Council, the California NET program is rapidly becoming a model from which other states can greatly benefit.

CALIFORNIA - Joan Haskins, San Francisco USD

Joan Haskins, Health Educator and licensed Sex Educator, originally taught life science and subsequently was hired as a health curriculum specialist for the San Francisco Unified School District. That position was terminated in June 1979. In our interview Joan corroborated much of what Gene Huber had said about health education in the San Francisco public school system.

In 1966-67 Dr. Frances Todd developed a "hands on" family life curriculum for K-12. She helped teachers teach, has lots of great materials and generated enthusiasm among young people. Two years ago Joan updated the curriculum to conform to the California Framework for Comprehensive Health Education, "but we really don't know what's going on." She indicated that feedback was better, partially from end-of-the-semester questionnaires, when she and Gene worked together and that really good in-service was available. "Now it has all gone by the boards."

Joan acknowledged that teachers not only do not have the time, energy or expertise to develop their own lesson plans, but that they also need good in-service. Last summer she assisted in running a week long workshop in Santa Barbara to help various California districts develop their health education programs. This was sponsored by funding from Pat Hill through the Comprehensive Health Education Act (1977). Joan discourages the transplanting of one district's curriculum into another without modifications dependent on the adopting district's specific needs. She recommended beginning with K-3 and noted San Francisco's exemplary kindergarten program "Growing Up Healthy", developed by Shirley Holder and others.

Joan appeared generally discouraged with the status of health education in San Francisco USD. "People give lip service to health education, but there's really nothing there." She was quick to point out, however, that health education is not alone in its deterioration.

CALIFORNIA - Pat Hill, Health Education Consultant

The California legal requirements for School Health Education, as stated in the California Education Code, specify instruction in personal and public safety and accident prevention including emergency first aid, hemorrhage control, treatment for poisoning, resuscitation techniques and cardiopulmonary resuscitation when appropriate equipment is available, and health, including venereal disease and the effects of alcohol, narcotics, drugs, and tobacco upon the human body. Health, including the principles and practices of individual, family and community health is also specified as a required area of study for grades 1-6. New legislation provides that the State Departments of Education and Health Services are to cooperate in the development of in-service training programs in dental health for teachers of grades K-6. The Education Code also requires satisfactory completion of a unit of health education for all individuals obtaining a teaching credential. Finally, the Code emphasizes the need for comprehensive health education and elaborates a plan for its implementation.

The Comprehensive Health Education Act of 1977 (SB 976) clarifies what is meant by "comprehensive health education," listing ten content areas roughly similar to those which are now the basis for the Health Instructional Framework for the California Public Schools* and stressing the importance of decision making and personal responsibility, as well as the need for community participarion in any effective health education program. Article 3 clarifies a plan for the implementation of these goals, for which Pat Hill is primarily responsible. This plan includes the development and evaluation of model curricula and instructional materials along with staff and community education. School districts wishing fiscal support in developing a comprehensive health education program must submit a plan for such a program to the State Department of Education. At this date, 20 projects, including 12 school districts and 8 county offices of education (representing an additional 81 school districts) are receiving portions of the $47,000 in State money that has been made available for this purpose in 1979-80.

This total amount of money for comprehensive school health education in California is noticeably minimal when compared with the 3.5 million dollars in State and Federal funds allocated to the Nutrition Education and Training Program (NET) in California during the last two years. Although Pat is able

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* Personal Health, Family Health, Nutrition, Mental-Emotional Health, Use and Misuse of Substances, Diseases and Disorders, Consumer Health, Accident Prevention and Emergency Health Services, Community Health and Environmental Health

to coordinate her efforts with others in the School Health Program Component who receive separate funding for different topic areas (sexually transmitted diseases, alcohol and drug abuse, genetic diseases and family life and sex education), having the NET program operate out of the Office of Child Nutrition Services, rather than out of the Division of Curriculum and Support Services of which the School Health Program is a component, has made communication a problem. While there has always been a problem of categorical funding, or a crisis approach to a problem, individual topic areas should be based on the Framework and integrated into a comprehensive health education curriculum.

Oakland is a good exmple of how the Framework may be utilized in the development of a teacher's guide for a comprehensive health education curriculum. With impetus from the Awareness and Action program, the Oakland PTA went to their school board, who in turn released twelve teachers for ten days to write a curriculum guide. They turned the illustrative objectives of the Framework into learning expectations (which can be measured), and added appropriate activities. Due to other problems, however, Oakland has been slow to implement the guide. Hayward, one of the 20 project districts mentioned above, is adapting Oakland's plan--a practice Pat endorses, rather than reinventing the wheel. In each project area there must be a plan to coordinate health services, health education and a healthful environment. There must also be community participation in planning, implementing and evaluating the program, although this is an area that often falls short of hopes and plans. Pat stressed that the 20 project areas are not necessarily exemplary, but that they are working to develop sound programs. Most of the available money goes for inservice training and curriculum development according to objectives in the Plan. Due to restrictions in the law, funds may not be used for released time.

One of the strengths of using the Framework as a guide for curriculum development is the opportunity to tailor a program so that it meets the needs of each individual community. Unfortunately, although the Framework went out to the principal in every elementary and secondary school in California, it often did not reach those people responsible for school health education programs and curriculum development thus contributing to what may be a pervasive ignorance of this useful tool. Another flexible curriculum guide was provided by the School Health Education Study (SHES) of 1961-63. Pat suggested that this deeply conceptual curriculum was ahead of its time, but that people are apt to be more receptive to it now. Long Beach Unified School District and Tustin Unified School District are among those who have bought this 3M produced curriculum. Unfortunately it is both costly, and not in print at this time.

Pat raised questions about the well known and highly promoted School Health Curriculum Project (SHCP) and Primary Grade Curriculum Project (PGCP) curricula, not only for their rigidity, but primarily for their emphasis on one body system per grade level rather than on preparing young people with the knowledge and skills which they will need to effectively face and deal with health related decisions and problems at various ages. It is for this very reason that the Framework's three main goals consist of self awareness, decision making and coping actions. Millions of dollars of federal government

funds have gone into the establishment of the SHCP over the last ten to twelve years and it has been almost impossible to obtain federal funds to develop and evaluate any other school health education program.

It is hoped that federal funds will be allocated for implementation of the federal Comprehensive Health Education Act passed by Congress in 1978 but not yet funded. Such funds would flow through the newly established Office of Comprehensive School Health in the Department of Education. Pat emphasized that funding for school health should come through education rather than public health channels in order to assure its most effective allocation. For example, in the recent "risk reduction program" administered by federal and state public health agencies, schools in California had less than two weeks to meet deadlines for applications, even though 35% of the funds were to go to the schools. Only two or three school districts were able to meet the deadlines.

In addition to the Comprehensive Health Education Program administered by the School Health Program Unit, the latter also operates an Alcohol/Drug Abuse Prevention Program, a Genetic Disease Education Program, a Sexually Transmitted Disease Education Program, a Family Life/Sex Education Program, and a Health Services Program. All offer leadership, consultation and inservice education to school and community personnel in the state.

A significant program to implement both the Health Instruction Framework and comprehensive health education has been a cooperative one with the California State PTA. The latter has received funding from the National PTA, through a grant from HEW, for five years for a "Health Education: Awareness and Action" program. With close cooperation from Pat Hill, a slide/tape presentation on comprehensive health education was developed and over 300 local PTA members were trained. The latter made presentations on comprehensive health education to local school boards and to other PTA members. The 1979-80 emphasis included a student health conference which will be a model for similar conferences in 1980-81. The deep involvement of parents in implementation of health education in California schools is a significant movement.

Coordination among health education agencies/organizations is achieved through the California School Health Alliance. The Alliance, composed of representatives of approximately 22 state level groups interested in and concerned about the health of school age children and youth, meets four times a year. It is chaired by a representative of the California School Boards Association and Pat Hill serves as Coordinator.

Pat feels that Far West Laboratory is in a good position to objectively evaluate school health education without partiality to any particular program. Any future work done by FWL in the area of School Health education should be undertaken in close cooperation with Pat Hill, Consultant in Health Education and Em. Riggs, Administrator, School Health Program.

CALIFORNIA - Gene Huber, San Francisco USD

Gene Huber was the Supervisor of Health Education in the San Francisco Unified School District up until three years ago. He was hired this year for only 64 days to coordinate the health education program and is discouraged by the district's declining commitment in this area. Although the program is coordinated on paper, there is usually no one to see that anything gets done. Site visits are minimal resulting in diminished awareness of what is actually going on in the schools. Materials have been lost while being shuffled to various offices. What remain often do not find their way into the classroom. A wealth of community resources go untapped for want of someone to make the necessary efforts.

Experienced teachers in the top salary brackets are not motivated to participate in what are now limited in-service opportunities. Many are swamped by increasing demands on their time, and health education is not a top priority. For about 4 or 5 years, each junior and senior high school had a health resource teacher available with one free period daily to organize an integrated health education program and stimulate other teachers. Health curriculum was taught in the following subject areas: 7th grade, physical education; 8th grade, science; 9th grade, social studies; 10th grade, family life and health education; 11th grade, physical education and social studies; and 12th grade, civics. Now only the 10th grade class remains, undermining the original multidisciplinary approach. As far as Gene can tell, health education at the elementary level most often focuses on nutrition and dental health; at the secondary level, on sex and drugs. Parental interest is low, and there is no pressure for change from the school board.

Past crises have motivated the PTA, who in turn inspired the development of exemplary programs. A newspaper headline in 1976 claimed "School Programming Holding the Line on V.D.," based on an apparent 50% drop in the disease in the 15-19 age group. Drug education programs proliferated during the Haight-Ashbury era. But when the pressure is off, these programs all fade out. Topic oriented funding (i.e., Project Teen Concern--addressing issues of premature parenthood) although excellent in what it has accomplished, also contributes to just the kind of haphazard lack of coordination thet the Comprehensive Health Education Act of 1977 was aimed at eliminating.

Although having benefited from the expertise of a variety of health professionals over the years (i.e., Herb Vandervort, Mary Mallory, Dr. Frances Todd, Dr. Pike, Joan Haskins and Gene Huber), San Francisco's School Health Education program is seriously suffering from the numerous cutbacks in educational funding. It seems to be a low priority concern.

CALIFORNIA - Ron Luyet, Palo Alto USD

Ron Luyet, Health Educator for the Palo Alto Unified School District, is responsible for 1) coordinating the Family Life and Health Education program for K-12, 2) all in-service training and curriculum development and 3) crisis intervention. These are jobs that used to be done by three different people. Cutbacks in funding and declining enrollment have taken their toll on Palo Alto's exemplary health education program. Parents are more concerned with keeping their schools open, their teachers hired and their children learning the traditional three Rs than with the quality of school health education. However, much of the original strength of Palo Alto's program stemmed from its sequential, comprehensive curriculum developed and coordinated by Sandy Snodgrass, and they have perpetuated some of that initial cohesiveness by retaining one person as overseer and advocate. For this reason, Palo Alto continues to be a model for other districts, despite all its necessary compromises.

Health curriculum for K-12 is primarily taught in separate units, rather than integrated into other subject areas. In K-6 units are taught when materials are available (they rotate between schols) thus introducing a somewhat artificial timing sequence. Inclusion of a health unit is primarily up to the discretion of the individual classroom teacher. A quarter unit on family life and health education is taught during grade 7 and human relations, peer counseling and family life and health education are all offered at the secondary level. Only about 50% of the students take advantage of these courses.

Competing demands on their time prevent many elementary teachers from receiving the in-service training necessary for them to make use of Palo Alto's extensive materials collection. Some of the teachers are also reluctant to teach subject matters with which they are uncomfortable (i.e., sex and drugs). Since teachers are not evaluated on their health instruction, motivation to put in extra time is often limited. These barriers to in-service participation contribute to a breakdown in communication between Ron and many individual teachers, compounded by his lack of time for extensive site visits.

Although working to take advantage of resources in the community, Ron is limited and frustrated by his lack of time. One notable innovation in response to a cutback in the school guidance services, has been the establishment of a marriage and family counseling internship with Santa Clara and Antioch students. Efforts have also been made to ease access to family service facilities in the community. Since research has emphasized the primary influence of the home on young people, Palo Alto is focusing much of their attention on parent education. Workshops have been offered on adolescent sexuality, alcohol and drug abuse, peer pressure, discipline, love and other subjects, all geared to improve parents awareness and effectiveness with their children. The PTA has been particularly instrumental in encouraging participation in and enthusiasm for these projects.

While many health units have pre-and post-tests built in to measure knowledge change, the assessment of attitude, belief and behavior change is much more difficult. The California Education Code 60650 "prohibits administering tests, questionnaires, surveys or examinations containing any questions about the pupils or his parents'/guardians' personal beliefs and practices in sex, family life, morality or religion to any pupil in kindergarten or grades 1-12 inclusive, unless the parent/guardian is notified in writing and they give written permission." Ron says "intuitively we feel that we're having an effect on values, attitudes and feelings, but we don't have the instruments to assess that." Other research, however, shows little support for the ultimate goal of successful health education as demonstrated in behavior change.

CALIFORNIA - Dr. Philip Nader, Physician

Dr. Philip Nader, Professor of Pediatrics and of Preventative Medicine and Community Health, and the Director of the Division of School Health and Community Pediatrics at the University of Texas Medical Branch in Galveston, is a visiting scholar (1979-80) with the Institute for Communication Research at Stanford and the Stanford Heart Disease Prevention Program. In our discussion, Dr. Nader stressed the importance of the utilization and integration of all of our resources in order to develop effective school health education programs. Community agencies, health care professionals, school health services and health educators, students and their families need to work together to maximize the development of positive health behaviors in young people. He was optimistic in suggesting that the cutback in educational funding may force a pooling of efforts if health education is to exist at all in the schools.

School health services offer an excellent opportunity for guidance in decision making and self care. The pattern of usage for young people parallels that of adults--a small number of visitors making a large number of visits. A perfect chance for early intervention is most often being overlooked.

In Galveston, Texas, pediatric medical residents are being trained to act as consultants to schools. Health professionals can provide valuable expertise expecially when in-service is by necessity minimal, and can offer assistance in tailoring a curriculum to the particular needs of each individual community.

A pilot study conducted by Dr. Nader in Monterey and Salinas suggested that student interest in a school heart disease prevention program carried over into the home. Tenth grade students in Monterey were shown a film version of a heart health test to assess their own risk and that of their parents. They then role played how they might intervene in their families to modify those risk factors. Although not statistically significant, more people in Monterey tuned in to a subsequent, longer version of the heart health test than in Salinas, where there had been no school program. This is a good example of how to begin to take advantage of the powerful interaction effect possible between the school and the home.

A recent smoking prevention program in San Jose (C.L.A.S.P.)* developed by the Stanford Heart Disease Prevention Program, deals primarily with peer pressure. Not only does the program make use of well respected non-smoking role models and teach skills for resisting peer pressure via films, it also attempts to restructure the whole social environment with the ultimate goal being the elimination of peer pressure to smoke. There are plans to eventually integrate alcohol, drugs and nutrition into this model. C.L.A.S.P.'s approach to health education goes way beyond the dissemination of information--they are focusing on the key factors in decision making that mediate health related behaviors.

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* See Resource Section p. 54.

School health education is useless to the child unless there is a major emphasis on the cognitive and social components that shape behavior. Without the integration of school, home and community, one should expect only minimal results.

NEVADA - Dr. Robert M. Hirsh (Education Consultant; Drug, Health, and Safety Education)

"The health program has never been a high priority effort in Nevada. Most secondary schools regard the program as 'something to get out of the way.'"

At the elementary level, health education is up to the initiative of individual classroom teachers and principals, resulting in a wide discrepancy in available programs. At the secondary level, those teaching the required health education semester must have at least a minor in Health Education. Of the 9½ unites in required areas of study necessary to graduate from high school in Nevada, ½ unit must be in Health Education. This unit is usually a standardized semester course taught in the sophmore year. It is also mandated that physiology and hygiene be offered, and a special emphasis on the effects of controlled substances on the human system.

Bob Hirsh has prepared a Comprehensive Health Education Guide for K-12. It covers the following topic areas along with relevant educational information and rationale for teaching, basic concepts and subconcepts, effective educational approaches and activities, suggested pupil outcomes, and grade level of recommended emphasis: alcohol, anatomy, community health, consumer health, dental health, disease control, drugs and narcotics, family relationships, health careers, heredity and environment, human growth and development, mental health, nutrition, physical fitness, physiology, safety and tobacco. Exemplary programs (i.e., Washoe County School District's Peer Counseling Program and Clark County's Parent/Student Drug Intervention Program) are described, and a comprehensive listing of sources for audiovisual and written materials is included. It is suggested that health information be coordinated across subject areas (i.e., Biology, Home Economics, Social Studies, Driver Education, etc.) in order to avoid unnecessary duplication.

This Comprehensive Health Education Curriculum is dated Sept. 1976, and Bob acknowledged wide variability in its use in 1980. Each district may decide what specific components it wishes to include in the standard tenth grade course. "For example, human sexuality is considered a component in one school district, but is not in the majority of others. Many of the smaller districts utilize our State Curriculum (all or in part). The two urban districts have developed their own courses. Other than physiology, hygiene, and the effects of controlled substances, most high schools, even within a given district, develop their own program." To Bob's knowledge, there have been no evaluation studies of health education in Nevada.

Although Planned Parenthood, Right-to-Life, March of Dimes, County Health Districts, Lung Association, and the Development Disabilities Commission have all developed/instituted programs, the Advisory Committees on human sexuality education (AB650) have refused to permit any outside resources dealing with sex education in the two urban districts. Bob knew of no application in Nevada for funding from the National Nutrition Training and Education Project.

Even though the state PTA has been extremely active in supporting efforts to create awareness of the importance of health education, the public continues to perceive health education as "something the P.E. teacher does with the kids when it rains." Bob suggests, however, that money is the major barrier to effective school health education in Nevada. "Generally, the educational community recognizes the importance of a sound comprehensive health education program. What is needed is a good inservice program for elementary teachers, with an exciting package of support materials - (and) a state-wide conference for secondary health instructors so that a feeling of unity and sharing can be developed."

UTAH - Dr. Robert Leake (Specialist in Health, Physical Education, Physical Education and Safety)

Utah's legislation calls for the instruction of students in the following health related areas: physiology, hygiene, the harmful effects of alcohol, tobacco and narcotics, sanitation, the causes and prevention of disease, and habits of healthful and happy living.

In the elementary grades, health is one of eleven recommended subjects to be taught by individual classroom teachers. Emphasis is on the establishment (in cooperation with home and community) of desirable basic health and safety practices and attitudes. The course of study is divided into nine strands (growing and developing, nutrition, daily health practices, preventing and caring for diseases, developing a positive self image/emotional health, tobacco, alcohol, drugs and health, safety and first aid, consumer health and community health) with instructional objectives, suggested grade level for emphasis and interrelationships with the broader eight maturities and curriculum goals (intellectual, ethical-moral-spiritual, emotional, social, health and physical, environmental, aesthetic and productive). Although the curriculum is carefully coordinated on paper, Bob admits that teachers teach what they like and may often simply follow a prepared text, or leave out an area altogether. Although the State Board of Education requires prospective elementary teachers to have some health education in their training, eliminating straight health education classes and integrating health information into other classes may have jeopardized the quality of instruction.

In either grade 7 or 8, one semester (approximately 90 hours) of health instruction is to be taught and in either grade 10, 11 or 12 (also approximately 90 hours). At the junior high school level "primary emphasis is given to personal hygiene, understanding the medical and scientific basis of helath practices, providing basic health information, and correcting common health misconceptions, developing an appreciation for the body and its contribution in living a quality life."

At the senior high school level, emphasis is on "helping the student acquire understanding and insight which enables him or her to become a discriminating consumer of health information, health practices, so-called "health" products, and health services. Another main purpose is to motivate the student to accept responsibility for self direction in matters of health that will contribute to the quality of his or her life now and throughout adulthood."

A recent revision of the secondary curriculum has organized content areas into five strands which are also correlated with the previously mentioned eight maturities. The five strands and their subtopic areas include:

1) Health Promotion - Wellness is a Lifestyle
   (physical fitness, sleep and rest, nutrition, dealing with stress, recreation and emotional health)

2) High Risk Health Practices
(overeating, overweight, tobacco use, alcholol use, outdoor survival, drug use, potential high spped impact activities (skiing, cycling, etc.) and emergency medical care)

3) Prevention and Care of Disease
(communicable diseases (common cold, influenza, childhood diseases, venereal disesases) and chronic diseases (heart, cancer, diabetes, arthritis, etc.)

4) Ethical Physical, Social and Emotional Understanding of Sex
(maturation, growth, development, consideration of the yet to be born, boy-girl relationships, Madison Avenue sale of sex and eroticism, the family, male and female reproductive systems, pregnancy, health issues of pregnancy and consequences of promiscuity)

5) Consumerism and Health
(information (sources), products and services)

The new secondary curriculum was planned with representatives from the state curriculum committees in science, social studies, homemaking, driver education and health and physical education, with the idea that some of the health related units would be taught primiarily in these different subject areas, and the health education classes would cover the rest. All units have been carefully elaborated with essential learnings, learning activities, desirable outcomes, materials and resources and teaching helps. Although it is clear that Bob and others have developed a thoughtful and comprehensive curriculum, teachers tend to use specific texts (Modern Health Investigation - Houghton Mifflin - junior high and Modern Health - Holt, Rineheart and Winston - senior high) rather than follow the state developed guidelines. Of those 327 teaching health education at the secondary level, only 4% are health education majors, 13% are science majors, 3% are social studies majors, 7% have miscellaneous majors and an overwhelming majority, 72%, are physical education majors.

Bob is responsible for coordinating the in-service and materials for all 40 school districts in Utah. He has the assistance of about eight district supervisors who he trains and who in turn work with their teachers. There is not much money for teacher released time and teachers are encouraged to give an hour of their time for every hour paid for by the district. The PTA recently lobbied for, and got, a $150,000 grant (for one year) to improve materials and instructional strategies. Bob is occasionally able to get small amounts of funding from private agencies and associations for special projects and materials development. This summer he is planning a week long workshop integrating health, safety, physical education and music, which will provide many teachers with the necessary inservice and guidelines so that they may be more likely to take advantage of the new curriculum. At this point there has been no formal evaluation of any of the curriculum, although it is a recognized need.

A recent survey of parents' priorities showed reading to be number one, followed by alcohol and drugs, and sex and violence. This year a bi-yearly Quality of Life Conference which has traditionally focused on teenagers and pregnancy will be geared more for parents. It will address issues of young

people and alcohol and will offer information about available resources in the community. Smith's Food Chain will sponsor a Health Fair with an emphasis on "Wellness" in September 1980, planned jointly by the State Divisions of Health and Education. Bob expects an enthusiastic turnout indicative of the support for preventative health care in the communities at this time.

Appendix B: Sampling of School Health Education Resources

The following resources include some of the material uncovered while reviewing school health education literature. They are listed here to facilitate further investigation by interested persons, but do not represent an endorsement by Far West Laboratory.

1. ALCOHOL AND DRUG ABUSE

- For information on setting up an alcohol education program for young people write:
  Ms. Judith Katz, Chief
  Youth Education Branch
  NIAAA
  5600 Fishers Lane
  Rockville, Maryland 20857

- Two films: Jackson Junior High (5-8) and Dial A-L-C-O-H-O-L (9-12) funded and sponsored by the U.S. Office of Education and NIAA
  National Council on Alcoholism
  733 3rd Avenue
  New York, NY 10017

- National Clearinghouse for Drug Abuse Information
  Alcohol, Drug Abuse, and Mental Health Administration
  5600 Fishers Lane, Room 10-A56
  Rockville, MD 20857 (301) 443-6500

2. COMPREHENSIVE (OR MULTIPLE TOPIC) CURRICULUM GUIDES

- "Being Healthy"--K-12 Curriculum guide similiar to "hands on" approach of the SHCP
  Maryland State Department of Education
  P.O. Box 8717
  Baltimore-Washington International Airport
  Baltimore, Maryland

- "Know Your Body"
  Developed by the American Health Foundation with a grant from the National Institute of Cancer
  7910 Woodmont Avenue, Suite 1320
  Bethesda, MD 20014 (301) 496-7070

  Emphasis on:
  1) Identifying risk factors
  2) Personal decision making
  3) Individualized health education
  4) Strategies for modifying lifestyles

- "The Most Important Person" - Multi-media program for primary-intermediate grade levels - Films produced by Sutherland Learning Associations under a grant from the Office of Child Development, U.S. DHEW
  Encyclopedia Britannica Educational Corporation
  425 N. Michigan Avenue
  Chicago, IL 60611

- Single copies of curriculum supplements and resource guides:
  1) Chronic and Degenerative Diseases
  2) Health and Fitness for Daily Living
  3) Nutrition
  4) Use and Abuse of Drugs, Alcohol and Tobacco
  Available from:
  The American Heart Association
  Texas Affiliate
  P.O. Box 15186
  Austin, TX 78761

- "Focusing on Health" - A Planning Guide for High School Health Education
  Streck-Vaughn Co.
  807 Brozos
  P.O. Box 2028
  Austin, TX 78768

- "Here's Looking at You" - K-12 Alcohol Education Program
  "Know Your Body" - Developed by Ernst Wynder, President of the American Health Foundation
  Comprehensive Health Education Foundation
  3002 North Union
  Tacoma, Washington 98407 (206) 759-5056

- "Feelin' Good" - National YMCA Cardiovascular Program materials for K-9
  Clayton Myers
  National Council of YMCAs
  291 Broadway
  New York, New York 10007

- "Growing Up Healthy" - Model K program
  Shirley Holder
  San Francisco Unified School District
  135 Van Ness Avenue
  San Francisco, CA 94102

- "Lifestyle Education Project" - targeted for low income individuals
  Tom Walker
  Milwaukee Health Department
  1230 W. Grant
  Milwaukee, WI 53215

- "Project Life"
  Thomas Walker (Director)
  Milwaukee Health Department
  841 N. Broadway, Room 112
  Milwaukee, WI 53202

3. FAMILY PLANNING

- National Clearinghouse for Family Planning Information
  Bureau of Community Health Services
  P.O. Box 2225
  Rockville, MD 20852 (301) 443-2430

4. FREE OR LOW COST MATERIALS

- "Educators Guide to Free Health, Physical Education and Recreation Materials" (Guide - $11.00)
  Lois Michaels
  The Health Education Center
  200 Ross Street
  Pittsburgh, PA 15219 or

  Education Progress Service, Inc.
  214 Center Street
  Randolph, WI 53956

- Sources of free or low cost health education materials for consumers
  Patricia A. Hamilton
  Office of Consumer Health Education, CMDNJ
  Rutgers Medical School
  Piscatawaw, NJ 08854 (201) 564-4500

5. HEALTH EDUCATION INFORMATION

- The following can be ordered from:
  Roy L. Davis - Director
  Community Program Development Division
  Bureau of Health, Education and Welfare
  Public Health Service - Center for Disease Control
  Atlanta, GA 30333
  1. Math Tech Inc., 1979: An Analysis of U.S. Sex Education Programs and Health Methods
  2. School Health Curriculum Project (SHCP)
  3. Primary Grades Curriculum Project (PGCP)
  4. Florida Managerial Model
  5. Health Education Project of the National Congress of Parents and Teachers
  6. The National Association of State School Boards of Education Health Project
  7. Catalogue of BHE's Publications on Health Education (1974-79)

- National Center for Health Education
  211 Sutter Street
  San Francisco, CA 94108 and

  901 Sneath Lane
  San Bruno, CA 94066

- American School Health Association
  National Office
  Kent, OH 44240

- Health Education Implementation in community, hospital and school
  W. Bernard Suttake
  New Jersey Dept. of Health
  P.O. Box 1540
  Trenton, NJ 08625

- Information on School Health Education in N.C. with emphasis on eight pilot projects (especially the role of the PTA and the Medical Society Auxiliary)
  Emma Carr Bivins
  Division of Health Services (Office of Health Education)
  P.O. Box 2091
  Raleigh, NC 27602

- Study to determine interest among school district decision makers to expand the school's role in providing preventative health programs
  Jeanne Coombs
  Harvard University School of Dental Medicine
  188 Longwood Avenue
  Boston, MA 02115

- Task Force report on School Health Education
  Marcia Pinkett-Heller
  New York State Commission on Health Education and Illness Prevention
  Twin Towers
  99 Washington Avenue
  Albany, NY 12210

6. MENTAL HEALTH

- National Clearinghouse for Mental Health Information
  National Institute of Mental Health
  5600 Fishers Lane
  Rockville, MD 20857 (301) 443-4517

7. NUTRITION

- Nutrition Education and Training Program (CA)
  Amanda Dew Mellinger
  State Coordinator of NETP
  California Department of Education
  721 Capitol Mall
  Sacramento, CA 95814 (916) 232-2468

8. SMOKING

- C.L.A.S.P. (Counseling Leadership About Smoking Pressures)
  American Lung Association of Santa Clara/San Benito Counties
  277 West Hedding Street
  San Jose, CA
  Director - Cheryl Perry

- Information about four pilot smoking education programs for adolescents
  Louis Cenci
  National Interagency Council on Smoking and Health
  291 Broadway
  New York, NY 10007

- Technical Information Center of the Office on Smoking and Health
  Parklawn Building - Room 1-16
  5600 Fishers Lane
  Rockville, MD 20857 (301) 443-1690

APPENDIX C: LIST OF INTERVIEWEES AND QUESTIONNAIRE RESPONDENTS

Interviewees

Gus Dalis
Health Education Consultant
Office of Los Angeles County

Linda Spaans Esten
Nutrition Education and Training Specialist

Joan Haskins
Health Educator
San Francisco Unified School District

Pat Hill
Health Education Consultant
California State Department of Education

Robert Leake
Specialist in Health Physical Education
Physical Education Safety
Utah State Department of Education

Gene Huber
Health Education Coordinator
San Francisco Unified School District

Ron Luyet
Health Educator
Palo Alto Unified School District

Philip Nader
Physician
Visiting Scholar, Stanford Heart Disease Prevention Program

Robert M. Hirsh
Education Consultant for Drug, Health, and Safety Education
Nevada State Department of Education

Respondents

Elizabeth Wilhelm
Clark County School District
Dorothy M. Seigle Diagnostic Center
420 S. 16th Street
Las Vegas, Nevada 89101
(702) 384-2733
(702) 736-5304

(a)* Alyce Taylor
Washoe County School District
425 E. 9th Street
Reno, Nevada 89520

(b) Rod Smith
(702) 322-7041

* a is elementary school district; b is secondary school district; neither a nor b means a unified school district.

Donald L. Hughes
Tooele County School District
70 N. 50 W.
Tooele, Utah 84074 (801) 882-3030

Frank Hall
Emery County School District
Huntington, Utah 84528 (801) 687-2489

R. Alden Black
Garfield County School District
Panquitch, Utah 84759 (801) 676-8821

Richard Towner
501 Argonaut Lane
Jackson, CA 95642 (209) 223-1883

Ralph Vilani
Fall River Jt. Unified School District
Fall River Mills, CA 96028 (916) 336-5515

Carolyn Harding
Fowler Unified School District
658 E. Adams
Fowler, CA 93625 (209) 834-2591

Joan Ainslie
St. Helena Unified School District
1325 Adams Street
St. Helena, CA 94574 (707) 963-2708

Ron Luyet
Palo Alto Unified School District
25 Churchill
Palo Alto, CA 94301

Dr. Bert C. Corona
Modesto City Elementary and High
Modesto, CA 95351 (209) 523-1851

Mary Jane Quick
Hayward Unified School District
P.O. Box 5000
Hayward, CA 94540

Mrs. Pat Allison
San Lorenzo Unified School District
15510 Usher Street
San Lorenzo, CA 94580 (415) 276-3600

(b) Douglas Campbell
Santa Rosa City High
217 Ridgeway
Santa Rosa, CA 95401

Dr. Ruth Rich
Los Angeles Unified School District
450 N. Grande
Los Angeles, CA 90012 (213) 625-6319

Gene Huber
Parks Side School
2550 25th Avenue (Room 20)
San Francisco Unified School District
San Francisco, CA 95126 (415) 565-9000

Mary Salocks
San Jose Unified School District
1605 Park Avenue
San Jose, CA 95126 (408) 998-6000

Helen Daniel
Stockton City Unified School District
701 N. Madison
Stockton, CA 95202 (209) 944-4000

Mrs. Edna Morgan
Sacramento City Unified School District
P.O. Box 2271
Sacramento, CA 95810 (916) 454-8011

APPENDIX D: QUESTIONNAIRE

FAR WEST LABORATORY
FOR EDUCATIONAL RESEARCH AND DEVELOPMENT

May 19, 1980

School health education is becoming one of the most frequently stated hopes for improvement in health that will not escalate the costs of health care. The Far West Laboratory in San Francisco is sponsoring an exploratory study of health education in the schools of its region (California, Nevada, and Utah). This questionnaire in part replicates the national School Health Education Study (SHES) of 1961-63. The following school districts have been selected in a stratified random sample for the first phase of the study:

California: Albany City, Berkeley, Fall River, Fort Bragg, Fowler, Fresno, Hayward, Jackson, Los Angeles, Modesto, Palo Alto, Sacramento, San Francisco, San Jose, San Lorenzo Santa Rosa, St. Helena, and Stockton.
Nevada: Carson County, Clark County, Elko County, Lyon County, Washoe County, and White Pine County.
Utah: Emery County, Garfield County, Granite County, Jordan, Ogden City, and Tooele County.

Your cooperation in completing and returning this questionnaire by May 30 will be greatly appreciated and will be acknowledged in our report to the Far West region. A copy of the report will be sent to you about the first week of July.

If you have questions about the study, please contact me at (415) 565-3032.

Sincerely,

Matilda Butler

Matilda Butler
Director, Health Education

1855 FOLSOM STREET · SAN FRANCISCO, CALIFORNIA 94103 · (415) 565-3000

THIS IS A GENERAL QUESTIONNAIRE THAT CANNOT TAKE ACCOUNT OF THE FACT THAT SOME SCHOOL DISTRICTS HAVE EXTENSIVE HEALTH EDUCATION PROGRAMS WHILE OTHER SCHOOL DISTRICTS HAVE LESS TO REPORT ABOUT AT THE PRESENT TIME. WOULD YOU PLEASE ANSWER ALL OF THE QUESTIONS AS THEY APPLY TO HEALTH EDUCATION IN YOUR DISTRICT. THANK YOU FOR YOUR TIME AND EFFORT.

1. Please indicate the grade level(s) at which the schools of your district cover any of the following health education topics by placing an "X" in the appropriate boxes.

	K-3	4-6	7-8	9	10	11	12
Accident prevention & safety							
Alcohol							
Community health							
Consumer education							
Dental health							
Diseases & disorders							
Drugs and narcotics							
Environmental hazards							
Exercise & relaxation							
Family life							
Food & nutrition							
Health careers							
Mental health							
Parenthood & childcare							
Personality development							
Physical changes during growth							
Sex education							
Skin care							
Smoking							
Structure & function of the human body							
Venereal diseases							
Vision & hearing							
Weight control							

2. Is health education taught as a separate subject in the elementary schools of your district? Is it integrated into other elementary subjects? Or both?

	K	1	2	3	4	5	6
Taught as a separate subject							
Integrated in other subjects							

3. Please describe health education courses taught in the secondary schools of your district. Please enter course names and circle other responses.

COURSE NAME	GRADE LEVEL?	REQUIRED OR ELECTIVE?	WHO TEACHES?
	7 10 8 11 9 12	Required Elective	Health educator Science teacher Home econ. teacher P.E. teacher Social studies teacher Other
	7 10 8 11 9 12	Required Elective	Health educator Science teacher Home econ. teacher P.E. teacher Social studies teacher Other
	7 10 8 11 9 12	Required Elective	Health educator Science teacher Home econ. teacher P.E. teacher Social studies teacher Other
	7 10 8 11 9 12	Required Elective	Health educator Science teacher Home econ. teacher P.E. teacher Social studies teacher Other
	7 10 8 11 9 12	Required Elective	Health educator Science teacher Home econ. teacher P.E. teacher Social studies teacher Other
	7 10 8 11 9 12	Required Elective	Health educator Science teacher Home econ. teacher P.E. teacher Social studies teacher Other
	7 10 8 11 9 12	Required Elective	Health educator Science teacher Home econ. teacher P.E. teacher Social studies teacher Other

4. In addition to separate health education courses, in which other subjects at the secondary level are specifically planned health units included? Please mark "X".

	7	8	9	10	11	12
General science						
Home economics						
Physical education						
Social studies						
Other, please specify _____						

5. Among the teachers who teach health education courses or units, roughly what percentage receive inservice training on health education? Please circle.

Elementary teachers	0%	10	20	30	40	50	60	70	80	90	100%
Secondary teachers	0%	10	20	30	40	50	60	70	80	90	100%

6. What role do the following resources play in your district's health education program? Please circle: No=no role, Minor=minor role, Major=major role.

	ELEMENTARY			SECONDARY		
State education code or state guidelines for health education	No	Minor	Major	No	Minor	Major
Local education code or guidelines	No	Minor	Major	No	Minor	Major
Guidelines prepared by other agency (e.g., Red Cross, Dairy Council, American Dental Association)	No	Minor	Major	No	Minor	Major
Locally developed teaching units	No	Minor	Major	No	Minor	Major
Texts/materials supplied by agency	No	Minor	Major	No	Minor	Major
Texts/materials derived from research and development (e.g., National Center for Health Education)	No	Minor	Major	No	Minor	Major
Commercially publishei texts/materials	No	Minor	Major	No	Minor	Major
District-level health educators or other specialists	No	Minor	Major	No	Minor	Major
Community physicians, dentists, nurses or nutritionists	No	Minor	Major	No	Minor	Major
Community police or fire personnel	No	Minor	Major	No	Minor	Major
Health agency staff or volunteers	No	Minor	Major	No	Minor	Major
Other, please specify _____	No	Minor	Major	No	Minor	Major

7. Which of the following problems related to health education concern your district? Please circle: No=not a concern, Minor=minor concern, Major=major concern.

Lack of time for health education in the curriculum	No	Minor	Major
Inadequate preparation of classroom teachers	No	Minor	Major
Lack of health education specialists	No	Minor	Major
Lack of a coordinated program through the grades	No	Minor	Major
Lack of good instructional materials on many topics	No	Minor	Major
Lack of support for health educaton from the community and school board	No	Minor	Major
Failure of parents to encourage practice of health habits learned in school	No	Minor	Major
Community opposition to controversial topics	No	Minor	Major
Student indifference to issues of good health	No	Minor	Major
Lack of participation by community professionals	No	Minor	Major
Shifting state and federal emphasis from one "fashionable" health topic to another	No	Minor	Major
Lack of adequate needs assessment	No	Minor	Major
Lack of information on instructional alternatives	No	Minor	Major

WE WILL ESPECIALLY VALUE ANY COMMENTS, PROGRAM PLANS, SYLLABI, OR OTHER MATERIALS THAT YOU WOULD CARE TO SHARE WITH OTHER DISTRICTS VIA OUR REPORT. THANK YOU AGAIN.